Illinois Department of Public Aid

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART I - (MUST BE COMPLETED)

Recipient Name (1) _____

Recipient Identification No. (2) _____

Physician Name (3) _____ Provider No. (4) _____

PART II - ACKNOWLEDGMENT

It has been explained to (5) _____ and her representative, if any, orally and in writing that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

(6) _____ (7) _____
Recipient or Representative Signature — Date

(8) _____ (9) _____
(If required, Interpreter Signature) — Date

PART III - PHYSICIAN STATEMENT

In my professional judgement, the hysterectomy is not being performed solely to accomplish sterilization; it is being performed for other medically necessary reasons.

(10) _____ (11) _____
Physician Signature — Date

PART IV - EXCEPTION REQUEST

☐ Exception 1 - I certify that the above named individual was already sterile at the time of the hysterectomy. The cause of the sterility was _____.

☐ Exception 2 - I certify that the hysterectomy performed on the above named individual was performed under life threatening emergency situation, i.e., _____. in which I determined prior acknowledgement of receipt of hysterectomy information was not possible. I have attached a copy of hospital operative record or other written explanation of nature of the emergency.

☐ Exception 3 - The above named individual had a hysterectomy performed during a period of retroactive Medicaid eligibility. Date of Surgery: _____. I certify that she was informed prior to the operation that the hysterectomy would render her permanently incapable of reproducing; or that Exception 1 ( ), or Exception 2 ( ), as certified above, made such explanation unnecessary or impossible.

_____ _____
Physician Signature — Date

Completion mandatory, Ill. Rev. State., Ch. 23, P.A. Code, penalty non-payment. Form approved by the Forms Management Center.